

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0023036</u></p> <p>Facility Name: <u>BAYSIDE TERRACE PARTNERSHIP</u></p> <p>Address: <u>1100 SOUTH LEWIS</u> <u>WAUKEGAN</u> <u>60085</u> Number City Zip Code</p> <p>County: <u>LAKE</u></p> <p>Telephone Number: <u>(847) 244-8196</u> Fax # <u>(847) 244-7647</u></p> <p>IDPA ID Number: <u>36-2886600</u></p> <p>Date of Initial License for Current Owners: <u>1976</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve N. Lavenda</u> Telephone Number: <u>(847) 236-1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td>(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Print Name and Title) <u>ROBERT A. ROSE, C.P.A.</u></td> </tr> <tr> <td>(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> <tr> <td>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u>	(Date) _____	Paid Preparer	(Print Name and Title) <u>ROBERT A. ROSE, C.P.A.</u>	(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																				
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Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP# 0023036 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>168</u>	Intermediate (ICF)	<u>168</u>	<u>61,488</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>168</u>	TOTALS	<u>168</u>	<u>61,488</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>0</u>				8
9	SNF/PED					9
10	ICF	<u>52,011</u>	<u>1,564</u>	<u>2,911</u>	<u>56,486</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>52,011</u>	<u>1,564</u>	<u>2,911</u>	<u>56,486</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.87%D. How many bed-hold days during this year were paid by Public Aid?
559 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 11/3/76J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAU ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP** # **0023036** Report Period Beginning: **01/01/00** Ending: **12/31/00**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	A. General Services											
1	Dietary	213,339	28,758	6,072	248,169		248,169		248,169			1
2	Food Purchase		234,276		234,276		234,276	(64)	234,212			2
3	Housekeeping	119,548	29,545		149,093		149,093		149,093			3
4	Laundry	15,121	6,641		21,762		21,762		21,762			4
5	Heat and Other Utilities			90,653	90,653		90,653	612	91,265			5
6	Maintenance	55,838	2,847	72,060	130,745		130,745	(22,254)	108,491			6
7	Other (specify):*											7
8	TOTAL General Services	403,846	302,067	168,785	874,698		874,698	(21,706)	852,992			8
	B. Health Care and Programs											
9	Medical Director			1,220	1,220		1,220		1,220			9
10	Nursing and Medical Records	723,980	70,275	15,541	809,796		809,796	(43,688)	766,108			10
10a	Therapy			2,966	2,966		2,966		2,966			10a
11	Activities	85,984	9,189		95,173		95,173	(701)	94,472			11
12	Social Services	243,761			243,761		243,761		243,761			12
13	Nurse Aide Training											13
14	Program Transportation			5,708	5,708		5,708		5,708			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,053,725	79,464	25,435	1,158,624		1,158,624	(44,389)	1,114,235			16
	C. General Administration											
17	Administrative	75,817		684,062	759,879		759,879	(524,312)	235,567			17
18	Directors Fees											18
19	Professional Services			71,219	71,219		71,219	(21,319)	49,900			19
20	Dues, Fees, Subscriptions & Promotions			27,559	27,559		27,559	(14,228)	13,331			20
21	Clerical & General Office Expenses	118,795	15,768	54,834	189,397		189,397	(40,666)	148,731			21
22	Employee Benefits & Payroll Taxes			231,832	231,832		231,832	(634)	231,198			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,861	17,861		17,861	(11,538)	6,323			24
25	Other Admin. Staff Transportation			542	542		542		542			25
26	Insurance-Prop.Liab.Malpractice			44,280	44,280		44,280	154	44,434			26
27	Other (specify):*							5,942	5,942			27
28	TOTAL General Administration	194,612	15,768	1,132,189	1,342,569		1,342,569	(606,601)	735,968			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,652,183	397,299	1,326,409	3,375,891		3,375,891	(672,696)	2,703,195			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

BAYSIDE TERRACE PARTNERSHIP
0023036
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V
LINE #

22 EMPLOYEE BENEFITS

2 FOOD

To reclass cost of employee meals from raw food to employee benefits

33 REAL ESTATE TAX

19 PROFESSIONAL FEES

To reclass cost of appealing real estate taxes

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			98,520	98,520		98,520	1,931	100,451		30
31	Amortization of Pre-Op. & Org.			2,709	2,709		2,709		2,709		31
32	Interest			30,435	30,435		30,435	(30,436)	(1)		32
33	Real Estate Taxes			69,119	69,119		69,119		69,119		33
34	Rent-Facility & Grounds							5,380	5,380		34
35	Rent-Equipment & Vehicles			2,291	2,291		2,291		2,291		35
36	Other (specify):*										36
37	TOTAL Ownership			203,074	203,074		203,074	(23,125)	179,949		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops			94,166	94,166		94,166	(94,166)			41
42	Provider Participation Fee			92,232	92,232		92,232		92,232		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			186,398	186,398		186,398	(94,166)	92,232		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,652,183	397,299	1,715,881	3,765,363		3,765,363	(789,987)	2,975,376		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,023	30		9
10	Interest and Other Investment Income	(8,911)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(64)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(150)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,436)	21		24
25	Fund Raising, Advertising and Promotional	(13,542)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(576)	20		28
29	Other-Attach Schedule	(209,797)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (262,453)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(527,534)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (527,534)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (789,987)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
BAYSIDE TERRACE PARTNERSHIP

Page 5A

ID# 0023036
Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1	Deferred Maintenance	\$	6 1
2	VETERANS EXPENSES	(43,640)	10 2
3	STATE REPLACEMENT TAX	(12,695)	21 3
4	1999 SEMINARS	(564)	24 4
5	NON-ALLOWABLE SEMINAR/TRAVEL	(2,424)	24 5
6	MISC INCOME - CRAFT SALES	(701)	11 6
7	MISC INCOME - JURY DUTY	(48)	10 7
8			8
9	1999 LEGAL EXPENSE	(468)	19 9
10	NON-ALLOWABLE EMPLOYEE BENEFITS	(1,423)	22 10
11	1999 HOLIDAY EXPENSE	(1,277)	22 11
12	COPE DUES - NON-ALLOWABLE	(278)	20 12
13	NON-ALLOWABLE SEMINAR/TRAVEL	(8,550)	24 13
14	VENDING INCOME	(94,166)	41 14
15	CAPITALIZED REPAIRS AND MAINTENANCE	(22,254)	6 15
16	NONALLOWABLE PROFESSIONAL FEES	(21,309)	19 16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
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87			87
88			88
89			89
90	Total	(209,797)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036** Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(64)											(64)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			612									612	5
6	Maintenance	(22,254)											(22,254)	6
7	Other (specify):*													7
8	TOTAL General Services	(22,318)		612									(21,706)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(43,688)											(43,688)	10
10a	Therapy													10a
11	Activities	(701)											(701)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(44,389)											(44,389)	16
	C. General Administration													
17	Administrative			(15,000)		(317,479)	(191,833)						(524,312)	17
18	Directors Fees													18
19	Professional Services	(21,777)		195		88	175						(21,319)	19
20	Fees, Subscriptions & Promotions	(14,546)		318									(14,228)	20
21	Clerical & General Office Expenses	(43,131)		2,465									(40,666)	21
22	Employee Benefits & Payroll Taxes	(2,700)		2,066									(634)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(11,538)											(11,538)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			154									154	26
27	Other (specify):*					1,930	4,012						5,942	27
28	TOTAL General Administration	(93,692)		(9,802)		(315,461)	(187,646)						(606,601)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(160,399)		(9,190)		(315,461)	(187,646)						(672,696)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP# 0023036

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	1,023		908									1,931	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,911)	(21,525)										(30,436)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			5,380									5,380	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(7,888)	(21,525)	6,288									(23,125)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(94,166)											(94,166)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(94,166)											(94,166)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(262,453)	(21,525)	(2,902)		(315,461)	(187,646)						(789,987)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				BAYSIDE TERRACE	HIGHLAND PARK	ESCROW
				NOTE PARTNERSHIP		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	32	MORTGAGE INTEREST	\$ 21,525	BAYSIDE TERRACE NOTE PARTNERSHIP	100.00%	\$	\$ (21,525)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 21,525			\$	\$ * (21,525)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00

Ending:

12/31/00**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$ 0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	\$ 612	\$ 612	15
16	V	19 PROFESSIONAL FEES	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	195	195	16
17	V	20 DUES, SUBS. & FEES	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	318	318	17
18	V	21 CLERICAL AND GENERAL	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	2,465	2,465	18
19	V	22 EMPLOYEE BENEFITS	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	2,066	2,066	19
20	V	26 INSURANCE	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	154	154	20
21	V	30 DEPRECIATION	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	908	908	21
22	V	34 RENT	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	5,380	5,380	22
23	V	0	0			0	0	23
24	V	0	0			0	0	24
25	V	17 HOME OFFICE	15,000	A.H.B. D/B/A ABH MANAGEMENT	100.00%	0	(15,000)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 15,000			\$ 12,098	\$ * (2,902)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	17 ADM. COMP.- DIRECT ALLOC.	\$	A.H.B. D/B/A ABH MANAGEMENT	100.00%		\$	15
16	V	27 EMP. BEN.-DIRECT ALLOC.		A.H.B. D/B/A ABH MANAGEMENT	100.00%			16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	17 ADMIN. - E. ROSENBAUM	\$	HEALTH RESOURCE, INC.	100.00%	\$ 49,750	\$ 49,750	15
16	V	19 PROFESSIONAL FEES		HEALTH RESOURCE, INC.	100.00%	88	88	16
17	V	27 PAYROLL TAXES		HEALTH RESOURCE, INC.	100.00%	1,930	1,930	17
18	V	0				0		18
19	V	17 MANAGEMENT FEES	367,229	HEALTH RESOURCE, INC.	100.00%	0	(367,229)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 367,229			\$ 51,768	\$ * (315,461)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V	17 ADMIN. - KARLA BISHOP	\$	KARLA BISHOP, INC.	100.00%	\$ 110,000	\$	110,000	15
16	V	19 PROFESSIONAL FEES		KARLA BISHOP, INC.	100.00%	175		175	16
17	V	27 PAYROLL TAXES		KARLA BISHOP, INC.	100.00%	4,012		4,012	17
18	V	0				0			18
19	V	17 MANAGEMENT FEES	301,833	KARLA BISHOP, INC.	100.00%	0		(301,833)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 301,833			\$ 114,187	\$ *	(187,646)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP** # **0023036** Report Period Beginning: **01/01/00** Ending: **12/31/00**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Earl Rosenbaum	General Partner	Fin. Operation	33.21%	See Attached	10	25.00%	Officer Salary	\$ 49,750	17-7	1
2	Karla Bishop	General Partner	Administration	6.55%	See Attached	20	50.00%	Admin Salary	110,000	17-7	2
3	Pam Price	Relative	LPN	0.00	0	40	100.00%	LPN Salary	37,145	10-1	3
4	Jack Bishop	Relative	Maintenance	0.00	0	40	100.00%	Maint. Salary	27,348	6-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 224,243		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization A.H.B. D/B/A ABH MANAGEMENT
 Street Address 411 CENTRAL AVENUE
 City / State / Zip Code HIGHLAND PARK, IL. 60035
 Phone Number (847)432-7262
 Fax Number (847)432-6095

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	3	\$ 1,554	\$	56,486	\$ 612	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	3	495		56,486	195	2
3	20	DUES, SUBS. & FEES	PATIENT DAYS	3	807		56,486	318	3
4	21	CLERICAL AND GENERAL	PATIENT DAYS	3	6,260		56,486	2,465	4
5	22	EMPLOYEE BENEFITS	PATIENT DAYS	3	5,247		56,486	2,066	5
6	26	INSURANCE	PATIENT DAYS	3	392		56,486	154	6
7	30	DEPRECIATION	PATIENT DAYS	3	2,305		56,486	908	7
8	34	RENT	PATIENT DAYS	3	13,660		56,486	5,380	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 30,720	\$		\$ 12,098	25

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization A.H.B. D/B/A ABH MANAGEMENT
 Street Address 411 CENTRAL AVENUE
 City / State / Zip Code HIGHLAND PARK, IL. 60035
 Phone Number (847)432-7262
 Fax Number (847)432-6095

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADM. COMP.- DIRECT ALLOC	AVG. HOURS WORKED	40	1	11,340				1
2	27	EMP. BEN.-DIRECT ALLOC.	AVG. HOURS WORKED	40	1	2,260				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 13,600	\$		\$	25

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization HEALTH RESOURCE, INC.Street Address P.O. BOX 1275City / State / Zip Code HIGHLAND PARK, IL. 60035Phone Number (847)432-7262Fax Number (847)432-6095

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMIN. - E. ROSENBAUM	AVG. HOURS WORKED	40	3	\$ 199,000	\$ 199,000	10	\$ 49,750	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	40	3	350	10	88		2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	40	3	7,720	10	1,930		3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 207,070	\$ 199,000		\$ 51,768	25

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization **KARLA BISHOP, INC.**Street Address **271 RIVERS DRIVE**City / State / Zip Code **LAKE BLUFF, IL. 60044**Phone Number **(847)432-7262**Fax Number **(847)432-6095**

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - KARLA BISHOP	AVG. HOURS WORKED	40	3	\$ 220,000	\$ 220,000	20	\$ 110,000
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	40	3	350	20	175	
3	27	PAYROLL TAXES	AVG. HOURS WORKED	40	3	8,025	20	4,012	
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					\$ 228,375	\$ 220,000		\$ 114,187

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP** # **0023036** Report Period Beginning: **01/01/00** Ending: **12/31/00**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	AMERICAN NATIONAL BANK	X		INDUSTRIAL REVENUE BON	VARIABLE	11/13/89	\$ 700,000	\$ 206,837	10/15/05	prim x .75	\$ 16,117	1	
2	BAYSIDE TERRACE NOTE	X		MORTGAGE	\$8,905.00	1/25/94	574,724	85,101	10/25/01	10.00%	13,486	2	
3	SUCCESS NAT'L BANK		X	AUTO LOAN	\$1,410.00	2/3/98	44,970	2,792	2/3/01	8.331%	833	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$10,315.00		\$ 1,319,694	\$ 294,730			\$ 30,436	9	
	B. Non-Facility Related*												
10	Supplemental Schedule											10	
11	INTEREST INC-NOTE PTSHI	X									(21,525)	11	
12	INTERST INCOME										(8,911)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (30,436)	14	
15	TOTALS (line 9+line14)						\$ 1,319,694	\$ 294,730			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number

BAYSIDE TERRACE PARTNERSHIP

0023036

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
1							\$	\$			\$
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21							\$	\$			\$

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036** Report Period Beginning: **01/01/00** Ending: **12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	69,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	67,019	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(2,481)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	71,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	69,119	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	63,691	8
	1996	64,783	9
	1997	66,405	10
	1998	67,580	11
	1999	67,019	12

2000 ACCRUAL = 1999 TAX + over accrual + 3%
67019+2481 = 69500 x 1.03 = 71,600 (rounded)

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP

0023036

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,360 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: 51,508 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 2,710 4. Dates Incurred: _____

Nature of Costs: FINANCING FEES

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY</u>	<u>104,671</u>	<u>1976</u>	<u>\$ 100,000</u>	1
2					2
3	<u>TOTALS</u>	<u>104,671</u>		<u>\$ 100,000</u>	3

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		1976	1973	\$ 1,082,366	\$ 43,295	35	\$ 40,844	\$ (2,451)	\$ 1,018,566	4
5	49		1986	1986	673,419	35,018	35	19,241	(15,777)	282,230	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1977		1,498		20			1,498	9
10	Various		1978		7,531		20			7,531	10
11	Various		1979		14,356		20			14,356	11
12	Various		1980		4,020		20			4,016	12
13	Various		1981		11,197		20			11,155	13
14	Various		1982		16,226		20			16,226	14
15	Various		1983		17,495		20			16,783	15
16	Various		1984		15,752	685	20	762	77	14,349	16
17	Various		1985		11,170	562	20	609	47	9,563	17
18	Various		1986		17,867	855	20	945	90	13,791	18
19	Various		1987		22,247	707	20	1,171	464	15,578	19
20	Various		1988		21,019	668	20	1,107	439	13,731	20
21	Various		1989		26,162	830	20	1,308	478	14,606	21
22	Various		1990		9,005	287	20	450	163	4,741	22
23	Various		1991		47,502	1,508	20	2,374	866	21,805	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				16,722			836	836	836	33
34	PAGE 12B TOTALS				55,267	845		2,315	1,470	3,273	34
35	PAGE 12A TOTALS				150,327	3,798		7,607	3,809	41,675	35
36	TOTAL (lines 4 thru 35)				\$ 2,221,148	\$ 89,058		\$ 79,569	\$ (9,489)	\$ 1,526,309	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1992		13,226	420	20	749	329	6,385	9
10	Various		1993		39,155	1,055	20	1,958	903	14,498	10
11	Various		1994		11,363	292	20	568	276	3,511	11
12	Various		1995		3,826	98	20	191	93	1,060	12
13	ROOF		1996		16,072	412	20	804	392	3,618	13
14	ELECTRICAL		1996		8,370	215	20	419	204	2,060	14
15	HVAC		1996		22,000	564	20	1,100	536	5,317	15
16	CARPETING		1996		3,266	84	20	163	79	774	16
17	HVAC		1996		4,280	110	20	214	104	999	17
18	VINYL FLOORING		1997		1,050		20	53	53	163	18
19	ENTRY SECURITY SYS.		1997		1,394		20	70	70	216	19
20	TCM BOARD		1997		623		20	31	31	111	20
21	CONCRETE PAVING		1997		2,850		20	143	143	453	21
22	HEATING		1997		682		20	34	34	130	22
23	TELEPHONE SYSTEM		1997		1,677		20	84	84	300	23
24	AUTO DOOR CLOSERS		1997		5,344	137	20	267	130	1,024	24
25	VINYL FLOORING		1997		1,050		20	53	53	168	25
26	WINDOW		1997		819		20	41	41	130	26
27	HUMIDIFIER		1998		1,158		20	58	58	58	27
28	COMPRESSOR		1998		1,786		20	89	89	89	28
29	CUBICLE CURTAINS		1998		2,260		20	113	113	113	29
30	COMPUTER WIRING		1998		2,000	384	20	100	(284)	100	30
31	MASONARY REPAIR		1998		1,570		20	79	79	79	31
32	HUMIDIFIER		1998		1,600		20	80	80	80	32
33	PAINT KITCHEN		1998		806		20	40	40	40	33
34	VINYL FLOORING		1998		1,050	27	20	53	26	146	34
35	VINYL FLOOR		1998		1,050		20	53	53	53	35
36	TOTAL (lines 4 thru 35)				\$ 150,327	\$ 3,798		\$ 7,607	\$ 3,809	\$ 41,675	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	ROOFTOP HTG & A/C		1999		6,410	164	20	321	157	375	9	
10	GUTTER REPAIR		1999		2,325		20	116	116	222	10	
11	FURNACE REPAIR		1999		782		20	39	39	72	11	
12	HOT WATER HEATER		1999		1,315		20	66	66	99	12	
13	CENDER BLOCKS		1999		1,100		20	55	55	73	13	
14	WINDOWS		1999		969		20	48	48	60	14	
15	ROOF REPAIR		1999		950		20	48	48	60	15	
16	CLOSED CIRCUIT TV'S		1999		711		20	36	36	36	16	
17	LANDSCAPING		1999		648		20	32	32	40	17	
18	ALARM REPAIRS		1999		1,242		20	62	62	109	18	
19	WATER RELIEF HOLE		1999		600		20	30	30	58	19	
20	HOT WATER HEATER REP		1999		648		20	32	32	51	20	
21	UNDERGROUND STORAGE		1999		2,200		20	110	110	193	21	
22	CURTAIN DRAINS		1999		2,550		20	128	128	160	22	
23	DRAIN TILE REPAIR		1999		2,000	51	20	100	49	133	23	
24	REMOVE&INSTALL DOORS		1999		1,498	38	20	75	37	100	24	
25	PARKING LOT REPAIR		1999		2,400		20	120	120	140	25	
26	KITCHEN REMODELING		1999		2,302	59	20	115	56	153	26	
27	GENERATOR		1999		13,884	356	20	284	(72)	450	27	
28	GENERATOR WIRING		1999		1,755	45	20	88	43	139	28	
29	CUSTOM DOORS		1999		3,838	98	20	192	94	272	29	
30	FREEZER REPAIR		1999		995		20	50	50	71	30	
31	INSTALL GENERATOR		1999		1,342	34	20	67	33	106	31	
32	ELECTRICAL		2000		870		20	4	4	4	32	
33	CALL LIGHT SYSTEM		2000		567		20	28	28	28	33	
34	ROOF REPAIRS		2000		675		20	34	34	34	34	
35	FURNACE REPAIRS		2000		691		20	35	35	35	35	
36	TOTAL (lines 4 thru 35)				\$ 55,267	\$ 845		\$ 2,315	\$ 1,470	\$ 3,273	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINTING			2000	2,400		20	120	120	120	9
10	FIRE DAMPER			2000	595		20	30	30	30	10
11	ADJUST CORRIDOR-REHAB COST			2000	(7)		20	(1)	(1)	(1)	11
12	CORRIDOR - REHAB			2000	13,734		20	687	687	687	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 16,722	\$		\$ 836	\$ 836	\$ 836	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP# 0023036

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP# 0023036

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$		4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP# 0023036

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP# 0023036

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
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25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP# 0023036

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
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25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 241,518	\$ 2,919	\$ 14,920	\$ 12,001		\$ 167,073	37
38	Current Year Purchases	6,317	2,890	345	(2,545)		345	38
39	Fully Depreciated Assets	247,492	135	616	481		247,386	39
40								40
41	TOTALS	\$ 495,327	\$ 5,944	\$ 15,881	\$ 9,937		\$ 414,804	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY BUSINESS	1990 DODGE VAN	1990	\$ 21,434	\$ 1,475	\$	\$ (1,475)	3	\$ 21,434	42
43	FACILITY BUSINESS	1998 LEXUS	1998	\$ 25,000	\$ 2,950	\$ 5,000	\$ 2,050	5	\$ 8,113	43
44										44
45										45
46	TOTALS			\$ 46,434	\$ 4,425	\$ 5,000	\$ 575		\$ 29,547	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 2,862,909	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 99,427	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 100,450	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 1,023	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,970,660	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	1998 EXCESS LEXUS COST	\$ 40,529	\$	\$ 13,153	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 40,529	\$	\$ 13,153	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

BAYSIDE TERRACE PARTNERSHIP
0023036
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
BAYSIDE TERRACE PARTNERSHIP	234,045	2,321	14,173	11,852	164,147
ALLOCATED FROM AHB, INC.	7,473	598	747	149	2,926
TOTALS	241,518	2,919	14,920	12,001	167,073

LINE 29: CURRENT YEAR

BAYSIDE TERRACE PARTNERSHIP	5,445	2,716	273	(2,443)	273
ALLOCATED FROM AHB, INC.	872	174	72	(102)	72
TOTALS	6,317	2,890	345	(2,545)	345

LINE 30: FULLY DEPRECIATED

BAYSIDE TERRACE PARTNERSHIP	233,568		460	460	233,568
ALLOCATED FROM AHB, INC.	13,924	135	156	21	13,818
TOTALS	247,492	135	616	481	247,386

TOTALS (Should Tie to Totals on Page 13)

BAYSIDE TERRACE PARTNERSHIP	473,058	5,037	14,906	9,869	397,988
ALLOCATED FROM AHB, INC.	22,269	907	975	68	16,816
TOTALS	495,327	5,944	15,881	9,937	414,804

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP**# **0023036**

Report Period Beginning:

01/01/00Ending: **12/31/00****XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	ALLOC-ABH				5,380			5
6								6
7	TOTAL				\$ 5,380			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? _____

☐ YES☒ NO16. Rental Amount for movable equipment: \$ **2,291**Description: **Pitney Bowes (postage meter) \$531.00; Air Savers (filters) \$1,760.00**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 0	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /2001 \$ _____13. /2002 \$ _____14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number **BAYSIDE TERRACE PARTNERSHIP** # **0023036** Report Period Beginning: **01/01/00** Ending: **12/31/00**
XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
			1	Licensed Occupational Therapist	N/A	hrs	\$		\$	
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	
2 Complex Medical Equip	
3 Oxygen	
4 Equipment Rental	
5	
6	
7	
8	
9	
10	
	<u> </u>
	<u> </u>
	<u> </u>
<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u> </u>
	<u> </u>
	<u> </u>

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 114,512	\$ 211,625	1
2	Cash-Patient Deposits	90,854	90,854	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	566,012	566,012	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	537,273	537,273	5
6	Prepaid Insurance	41,594	41,594	6
7	Other Prepaid Expenses	12,128	12,128	7
8	Accounts Receivable (owners or related parties)	16,419	16,419	8
9	Other(specify): See supplemental schedule	70,825	70,825	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,449,617	\$ 1,546,730	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		85,101	11
12	Long-Term Investments			12
13	Land	100,000	100,000	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	2,158,410	2,158,410	15
16	Equipment, at Historical Cost	558,743	558,743	16
17	Accumulated Depreciation (book methods)	(2,256,720)	(2,256,720)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	13,203	13,203	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 573,636	\$ 658,737	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,023,253	\$ 2,205,467	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 563,340	\$ 563,340	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	90,854	90,854	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,421	63,421	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,499	90,324	31
32	Accrued Real Estate Taxes(Sch.IX-B)	71,600	71,600	32
33	Accrued Interest Payable	154	154	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	21,401	28,041	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 830,269	\$ 907,734	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	209,629	209,629	39
40	Mortgage Payable	85,101	85,101	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 294,730	\$ 294,730	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,124,999	\$ 1,202,464	46
47	TOTAL EQUITY (page 18, line 24)	\$ 898,254	\$ #REF!	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,023,253	\$ #REF!	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 813,683	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 813,683	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	834,571	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(750,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 84,571	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 898,254	24

* This must agree with page 17, line 47.

Facility Name & ID Number	BAYSIDE TERRACE PARTNERSHIP#	0023036	Report Period Beginning:	01/01/00	Ending:	12/31/00
---------------------------	------------------------------	---------	--------------------------	----------	---------	----------

Balance per General Ledger	813,683
Adjustments:	

-
-
-

Total adjustments

-

Balance - Beginning of Year

813,683

Equity(Deficit) from Page 17 Col 1

898,254

Related Party
Equity(Deficit)
Income

83224
21525

104,749

Combined Equity - End of Year

1,003,003

Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP

0023036

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,445,451	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,445,451	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	102,413	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 102,413	23
	D. Non-Operating Revenue		
24	Contributions	4,000	24
25	Interest and Other Investment Income***	22,295	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,295	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	25,775	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,775	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,599,934	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	874,698	31
32	Health Care	1,158,624	32
33	General Administration	1,342,569	33
	B. Capital Expense		
34	Ownership	203,074	34
	C. Ancillary Expense		
35	Special Cost Centers	94,166	35
36	Provider Participation Fee	92,232	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,765,363	40
41	Income before Income Taxes (line 30 minus line 40)**	834,571	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 834,571	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

DESCRIPTION	AMOUNT
1 Vending Commissions	
2 JURY DUTY INCOME (ADJUSTED OF P.5)	48
3 CRAFT SALES (ADJUSTED OFF P.5)	701
4 THEFT AND LOSS RECOVERY (NOT OFFSET, SINCE CONSIDERED	21,732
5 A NON-ALLOWABLE EXPENSE IN THE YEAR REPORTED	
6 1999)	
7 STATE REPLACEMENT TAX - OVERACCRUAL	3,295
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u>25,776</u>

Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP

0023036

Report Period Beginning:

01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

(This schedule must cover the entire reporting period.)						
		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,115	\$ 66,640	\$ 31.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,578	4,698	52,788	11.24	3
4	Licensed Practical Nurses	14,313	16,685	287,212	17.21	4
5	Nurse Aides & Orderlies	35,982	37,622	317,340	8.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,339	8,834	85,984	9.73	10
11	Social Service Workers	18,918	20,211	243,761	12.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,735	22,632	213,339	9.43	15
16	Dishwashers					16
17	Maintenance Workers	3,289	4,187	55,838	13.34	17
18	Housekeepers	12,221	13,579	119,548	8.80	18
19	Laundry	1,744	2,084	15,121	7.26	19
20	Administrator	2,080	2,185	75,817	34.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,809	13,924	118,795	8.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	136,088	148,756	\$ 1,652,183 *	\$ 11.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

B. CONSULTANT SERVICES					
		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 6,072	1-3	35
36	Medical Director	monthly	1,220	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	4,500	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	56	2,966	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	56	\$ 14,758		49

C. CONTRACT NURSES

C. CONTRACT NURSES					
		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	291	\$ 11,041	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	291	\$ 11,041		53

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		\$	\$
0	0	\$ 0	#DIV/0!

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
DEMETREA RAPHAEL	ADMIN		\$ 75,817	Workers' Compensation Insurance		\$ 23,994	IDPH License Fee		\$
				Unemployment Compensation Insurance		9,972	Advertising: Employee Recruitment		3,122
				FICA Taxes		124,271	Health Care Worker Background Check		303
				Employee Health Insurance		20,653	(Indicate # of checks performed 25)		
				Employee Meals			ADVERTISING		3,400
				Illinois Municipal Retirement Fund (IMRF)*			DUES AND SUBSCRIPTIONS		1,889
				UNION HEALTH AND WELFARE		43,582	LICENSE AND FEES		1,400
				HOLIDAY EXPENSE		6,083	SPECIAL DUES - ICLTC		6,299
				EMPLOYEE BENEFITS		176	ALLOC-AHB, INC.		318
				EMPLOYEE MEALS (net)		401	YELLOW PAGE ADVERTISING		576
				ALLOCATED FROM AHB, INC.		2,066	Less: Public Relations Expense		()
							Non-allowable advertising		(3,400)
							Yellow page advertising		(576)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 13,331
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)		\$ 231,198	G. Schedule of Travel and Seminar**		
Description				Description		Line #	Description		Amount
			Amount						
HEALTH RESOURCE INC - MANAGEMENT FEES			\$ 367,229					Out-of-State Travel	\$
KARLA BISHOP, INC. - ADMINISTRATIVE FEE			301,833						
AHB, INC - HOME OFFICE EXPENSE			15,000						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								In-State Travel	
C. Professional Services									
Vendor/Payee	Type		Amount						
SACHOFF AND WEAVER	LEGAL		\$ 2,959						
HOLLEB AND COFF	LEGAL		9						
TENNEY AND BENTLEY	LEGAL		676						
FROST, RUTTENBERG AND									
ROTHBLATT, P.C.	ACCOUNTING		60,655						
ALPHA DATA	DATA PROCESSING		2,948						
LAWRENCE WEBER MEDICAL	COMPUTER SUPPORT		2,500						
JANE OSA	PENSION ADMIN FEES		1,473					Seminar Expense	6,324
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		()
			\$ 71,220				TOTAL		\$ 6,324

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number BAYSIDE TERRACE PARTNERSHIP

0023036

Report Period Beginning: 01/01/00

Ending: 12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC-\$6299
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 92,232
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 401
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of line 14
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw